

epidemiologic, clinical, and other laboratory data?

2. What is the reproducibility and predictive value of these tests in screening settings, diagnostic settings?
3. Can rapid diagnostic tests for the presence of HTLV-III/LAV or viral antigens be developed?
4. Can viral subtyping systems be developed?
5. What is the qualitative (and quantitative) ability, compared to blood, to recover HTLV-III/LAV from:
 - a. Cervical secretions, menstrual blood, and vaginal specimens?
 - b. Urine?
 - c. Feces?
 - d. Sweat?
 - e. Saliva?
 - f. Semen?
 - g. Respiratory secretions?
 - h. Fomites?
 - i. The environment?
 - j. Animals and insects?

6. What is the relationship between simian T-lymphotropic virus, type III, and similar viruses in primates and HTLV-III/LAV in humans?
7. Under what conditions may HTLV-III/LAV be inactivated by drying, heating, ultraviolet light, commonly used chemical germicides (including those not yet tested as well as those that have been tested under uncontrolled conditions), and in-use disinfection and decontamination procedures, including use of appropriate medical devices?
8. Can results of studies of the natural history of nonhuman primate viruses be applied to understanding manifestations of HTLV-III/LAV infections?

Reference

1. Public Health Service plan for the prevention and control of acquired immune deficiency syndrome (AIDS). Public Health Rep 100: 453-455, September-October 1985.

LETTER TO THE EDITOR

Gynecomastia Among Ethiopian Jews

We have read with interest the article by Sattin and coworkers in *Public Health Reports* (99: 504-510, September-October 1984), "Epidemic of Gynecomastia Among Illegal Haitian Entrants."

Their article prompted us to investigate another immigrant population, one that had experienced severe starvation in Ethiopia before being brought to Israel in the "Moses Operation" early in 1985. Once in Israel, these Ethiopian Jews received markedly improved nutrition and medical care.

In a pilot study at the Romema Health Center in Haifa, 16 male refugees, aged 10-60, were examined. Eight had bilateral gynecomastia of grade 1 to grade 3 according to the classification of Nydick and coworkers (1); one had unilateral gynecomastia; none had breast sensitivity or secretion. The examinations were carried out about 4 months after their arrival. Among an age-matched comparison group of Romema residents, there was no bilateral gynecomastia and only one case of unilateral gynecomastia in a 14-year old boy.

This statistically significant increased prevalence of gynecomastia among refeed Ethiopians is not explained either by a response to INH therapy for tuberculosis or

by age effects such as delayed adolescence. We suggest that this may be another example of refeeding gynecomastia in another refugee population. We shall submit the data from this study for publication and plan to extend this study to a larger population of immigrant Ethiopian Jews in the light of these findings.

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Reference

1. Nydick, M., Bustos, J., Dale, J. H., and Rawson, R. W.: Gynecomastia in adolescent boys. *JAMA* 178: 449-454, Nov. 4, 1961.